

Diabetes Self-Management Training Participant Questionnaire/Self Assessment For Gestational Diabetes

General Information:

Name: _____ Date _____

Address: _____

_____ Age: _____

What name would you like us to use? _____

Person filling out form: _____

Relationship: _____

Reason for not filling out form yourself: _____

How did you hear about this program? _____

Check your racial/ethnic group:

- | | |
|---|---|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> African American/Black |
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asian/Chinese/Japanese/Korean/Pacific Islander | |
| <input type="checkbox"/> Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino | |

Social:

Do you work? ☐ Yes ☐ No ☐ Student ☐ Disabled

Type of job and hours? _____

Who lives with you? _____

How far in school did you go? _____ How do you learn best? (check **all** that apply)

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Listening | <input type="checkbox"/> Group discussion |
| <input type="checkbox"/> Seeing/visual | <input type="checkbox"/> Doing | <input type="checkbox"/> Watching videos/TV |
| <input type="checkbox"/> Computer | <input type="checkbox"/> Other _____ | |

What language do you use at home? _____

Does your insurance cover all or part of:

- ☐ Health care provider visit ☐ Diabetes Education
Supplies: ☐ meters ☐ strips ☐ lancets ☐ other
(Note: Call insurance for this information)

If you have no insurance, can you pay for these things? ☐ Yes ☐ No

Medical History:

List other health problems _____

Have you been hospitalized for diabetes? ☐ no ☐ yes where? _____Do you have any allergies ☐ no ☐ yes _____Do you get flu shots? ☐ No ☐ Yes: Date of last flu shot: _____Do you drink alcohol? ☐ No ☐ Yes: What kind? _____How much do you usually drink? ☐ Daily ☐ 2-4 times/week☐ Once a week ☐ Occasionally ☐ Other _____Do you smoke cigarettes? ☐ Yes ☐ NoIf yes, would you like information about quitting? ☐ Yes ☐ No**All Medications:** Include those needing a prescription and not needing a prescription (over-the-counter – for example aspirin, Ibuprophen)

Name of Medication	Amount	What is it for?

Do you use, vitamins, herbal or home remedies, teas or supplements?

☐ No ☐ Yes: List

Vitamin/supplement/herbal/home remedy/teas	What do you take it for?

Pregnancy History

Due date: _____

How many children are living? _____ Were they all full term? ☐ Yes ☐ No

How much did they weigh? _____

Did you have any problems during your pregnancies? ☐ Yes ☐ No; if yes, explain: _____**Nutrition:**

Height: _____ Pre pregnancy weight: _____ Current weight: _____

Have you ever seen a dietitian (RD) for diabetes? ☐ Yes ☐ No If yes, when? _____Do you have a meal plan? ☐ Yes ☐ No Do you follow it? ☐ Yes ☐ No: Why not? _____

How many meals do you eat daily? _____
 How many snacks daily? _____ What kind? _____
 Who cooks? _____ Who shops? _____
 Do you have any religious/family customs or celebrations that involve food or eating?
 Explain: _____

How often do you eat out or bring home "take out"? _____
 Where? _____
 List Food allergies: _____

Diabetes History:

Have you ever had diabetes with a pregnancy before? ☐ Yes ☐ No; If yes, when? _____

Have you had diabetes education in the past? ☐ No ☐ Yes (check box below and write date and place)

☐ Self-taught (explain how): _____

☐ Physician's office:

Name: _____

☐ Group classes: _____

☐ One-to-one meeting/s with diabetes educator _____

Do you check your blood sugar? ☐ No ☐ Yes: How often _____ and what do they run? _____

Have you been hospitalized during this pregnancy? ☐ No ☐ Yes: why? _____

Do you know what the results were for any of the following tests?

Test	Result	Date
Fasting blood glucose		
1 hour after glucose load		
2 hours after glucose load		
3 hours after glucose load		

Activity/Exercise:

How often are you active? ☐ None ☐ Some ☐ Often

Are you as active as you think you should be? ☐ Yes ☐ No: If no, why not? _____

What do you do to be active or to exercise: _____

More About You

How interested are you in learning about diabetes?

(not at all)

(very much)

1 —————> 2 —————> 3 —————> 4 —————> 5

How stressed are you?

Not

Very

1 —————> 2 —————> 3 —————> 4 —————> 5

Not

Very

How do you handle things that worry you? _____

What concerns or worries do you have for you or your baby? _____

What is, or will be, the hardest part of taking care of your diabetes? _____

My diabetes is a ☐ Disaster ☐ Burden ☐ Problem ☐ Challenge ☐ Opportunity

What are some of the ways your family might have treated diabetes? _____

How does your faith or religion help you to be well? _____

Name 1 goal you have for your diabetes: _____

Do you plan to have more children? ☐ Yes ☐ NoDo you use birth control? ☐ No ☐ Yes: what kind? _____

For Instructional Staff Only: Education Plan: ☐ Provide instruction for specific content area/s
checked on "Education Plan and Record" ☐ Individual appointments ☐ Group classes ☐ Plan to
address special educational
needs _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____